Northwest Community EMS System

Request for Exposure Determination

Instructions: DICO will complete after consultation with EMS personnel immediately after a potential exposure as defined in System Policy I2.
If Exposure is confirmed, DICO will complete & transmit Request for Source Patient Testing to receiving facility to begin testing. Place this form in employee's file.

Pre-hospital Provider Information

EMS Agency:	Exposure date & time:	Date report filed:
Name(s) of all exposed personnel (PRINT):		
Name of individual followed by this report:		
DICO:	Date/time notified:	Date/Time responded:
Specific location where exposure took place:		

Source Patient Info

Name: Gender: Age: RUN **#:**

Type of exposure (Check all that apply)

☐ Bloodborne	☐ Airborne/respiratory	☐ Pt coughing	☐ Pt febrile	☐ Positive pt Hx	☐ < 3 ft. from pt.
☐ Needlestick	☐ Deep puncture	☐ Scratch	☐ Inhalation	☐ Blood splash	☐ Fluid splash

Type & amount of body fluids involved:

Blood visible in OPIM? [ ] Yes [ ] No

Percutaneous Exposure

Depth of injury:
Fluid injected? [ ] Yes [ ] No
Blood visible? [ ] Yes [ ] No

Skin / mucous membrane exposure

Duration of contact:

Condition of skin:[ ] Chapped [ ] Abraded [ ] Intact

Identify the specific part(s) of body exposed/injured: [ ] Hands [ ] Face [ ] Nose [ ] Mouth [ ] Eyes
Other:

Procedure being performed:
Explain how the exposure occurred:

Did sharp involved have engineered injury protection? **[ ] Yes [ ] No** Type & brand of device:
If yes, when did the injury occur? [ ] Before activation of protective mechanism [ ] After activation of protective mechanism

Classify the cause of the exposure (Check all that apply)

☐ Accidental	☐ Not wearing PPE	☐ Lack of awareness of environment
☐ Improper procedure	☐ Defective equipment	☐ Improper disposal of OPIM/sharps

Indicate the PPE in use at the time of exposure:

☐ Gloves	☐ Surgical mask	☐ N-95 mask	☐ Eye protection Type:	☐ Gown	☐ None

If none, explain circumstances that precluded use of barriers:

Health history of exposed individual: **File checked for:** Prior history of Hepatitis B? [ ] Yes [ ] No

Completed Hep B vaccine series [ ] Yes [ ] No	Prior hx +HIV test [ ] Yes {] No	Prior hx positive TB skin test [ ] Yes [ ] No
Hepatitis AB test positive: [ ] Yes [ ] No	Date last tetanus:	Date last TB skin test or chest X-Ray:

This potential exposure is determined to be [ ] CONFIRMED [ ] NOT CONFIRMED

Receiving facility ____ Exposure reported to:____________________________________

Request for source patient testing transmitted at:______________________**UNIQUE IDENTIFIER:**_________________________

Employee notified of Source Patient test results: [ ] Yes [ ] No Date:_______________________Time:__________________

Employee Medical Follow – Up Referred to ____

PRINT NAME/*Signature***of DICO**:____